STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155267	A. BUILDING 01 B. WING	04/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT VILLA NURSING AND REHABILITATION CENTER	545 W MOONGLO ROAD SCOTTSBURG, IN47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/04/11 Facility Number: 000168 Provider Number: 155267 AIM Number: 100267020 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Scott Villa Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, Chapter 18, New Health Care Occupancies for the Therapy Wing, and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 70 and had a	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	census of 55 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/08/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following			

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K0018 SS=E	Based on observation and interview, the facility failed to ensure 8 of 101 corridor doors would latch and resist the passage of smoke with no impediment to closing the doors. This deficient practice affects any residents using the Main Entrance Hall, 2 residents who reside in room 407, and 2 residents who reside in room 200. Findings include: Based on observation on 04/04/11 during a tour of the facility from 11:00 a.m. to 1:30 p.m. with the maintenance director, the corridor doors to the medical records room in the Main Entrance Hall, the staff office next to the beauty shop, the beauty shop, the referral office, the business office, and resident room 407 were propped open with metal door props attached to the bottom of each door. Furthermore, the maintenance office door was propped open with a rope attached to the door knob and tied to the wall behind the door. The door to resident room 200 failed to latch into the door frame leaving a one inch gap along the latching side of the door. Based on an interview with the maintenance director on 04/04/11 at 12:10 p.m., the doors to some rooms in the facility shut by themselves and some staff and residents like to have their doors propped open, so metal door props were installed.	K0018	No residents were affected by this deficient practice.Corridor doors to the medical records room, staff office next to beauty shop, the beauty shop, the referral office, the business office and resident room 407 have had metal door props removed. The door to room 200 has been adjusted and is latching into door frame. The rope was removed immediately from the maintenance door.All other doors in facility were checked to assure no other doors were propped open with metal door props or any other item.Rounds will be completed weekly for 12 weeks by the Maintenance supervisor or designee then monthly to assure doors are not propped open and latch correctly.Logs of weekly rounds will be reviewed for any concerns identified at monthly QA meetings for four months.	04/22/2011

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	3.1-19(b)			

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K0025 SS=F	Based on observations and interview, the facility failed to ensure 3 of 3 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. This deficient practice affects all residents in the facility. Findings include: Based on observation with the maintenance director on 04/04/11 at 1:00 p.m., the following smoke barrier walls above smoke barrier doors had penetrations which were not fire stopped or were missing drywall: a. The 100 Hall smoke barrier wall had a four inch by four inch area of drywall missing around a water pipe penetration. b. The 400 Hall smoke barrier wall had three, one inch to three inch gaps around electrical piping passing through the smoke barrier wall with no fire stopping material around the gaps. c. The 200 Hall smoke barrier wall had two, one inch gaps around water piping penetrations with no fire stopping material around the gaps. These smoke barrier penetrations were verified by the maintenance director at the time of observations. 3.1-19(b)	K0025	No residents were affected by this deficent practice.a. the 100 hall smoke barrier wall had the drywall replaced.b. the 400 hall smoke barrier wall had fire caulking placed in the two one inch to three inch gaps around electrical piping.c. 200 hall smoke barrier wall had the fire caulking placed in the two one inch gaps around water piping penetrations.All smoke barrier walls have been checked for any other penentrations and none were found.Any contractor who bids a job involving going through smoke barrier walls will be required to include replacement of fire caulking.The Administrator or Maintenance supervisor will review all bids from contractors to assure fire caulking is included in the bid.	04/22/2011

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K0029 SS=E	Based on observation and interview, the facility failed to ensure 1 of 5 hazardous areas where soiled linen was stored was separated from other spaces by smoke partitions and a self closing door. This deficient practice could affect any residents who use the main dining room located near the exit door in the Service Hall. Findings include: Based on observation on 04/04/11 at 11:00 a.m. and at 12:05 p.m. with the maintenance director, the Service Hall had two, thirty three gallon soiled linen receptacles stored in the corridor next to the south exit door. Based on an interview with the maintenance director on 04/04/11 at 12:05 p.m., the soiled linen receptacles are used throughout the day and stored next to the Service Hall south exit door after their use. 3.1-19(b)	K0029	No residents were affected by the deficient practice.The 33-gallon soiled linen receptacles were immediately removed from the service hall.The 33-gallon soiled linen receptacles were taken out of service. All halls were checked and no other 33-gallon soiled linen receptacles were found in halls.Rounds will be made 5x/wk for four weeks then weekly for four months by Housekeeping Supervisor to assure no 33-gallon linen receptacles are in halls.Results of rounds will be reviewed monthly at QA meeting for four months.	04/22/2011

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K0038 SS=F	1. Based on observation and interview, the facility failed to ensure 6 of 6 exit accesses supplied with delayed egress locks, unlocked when force was applied to the releasing device or were provided with a sign indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. 7.2.1.6.1, allows approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided the following criteria are met: (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor be	K0038	No residents were affected by the deficient practice.1. Signs indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS were ordered and will be placed on all six doors that are equipped with delayed egress locks.Egress doors equipped with delayed egress locks were checked and will have a sign put in place.Egress doors equipped with delayed egress locks will be checked monthly to assure appropriate signage is present by Maintenance supervisor or designee.Monthly checks will be reviewed at monthly QA meeting for six months.2. The five foot long bench has been removed from the concrete slab outside the main dining room exit discharge onto sidewalk leading to the paved parking lot.There are no other exits equipped with delayed egress locks in the facility.The six exits equipped with delayed egress locks will be monitored 5x/wk for four weeks then weekly by maintenance supervisor or designee to assure exits are not blocked.Audits will be reviewed at monthly QA meeting for six months.	04/22/2011

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	required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay no exceeding 30 seconds shall be permitted. (d) On the door adjacent to the releasing device, there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice affects all residents in the facility. Findings include: Based on observations on 04/04/11 during a tour of the facility with the maintenance director from 11:00 a.m. to 1:30 p.m., all six exits in the facility were each equipped with delayed egress locks. Furthermore, the six exit doors were not provided with a sign indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This was verified by the maintenance director at the time of observations.			

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 6 exit accesses was readily accessible at all times. This deficient practice could affect any resident using the main dining room exit. Findings include: Based on observation on 04/04/11 at 11:40 a.m. with the maintenance director, the main dining room exit discharged on to a concrete sidewalk leading to the paved parking lot. The concrete slab at the parking lot had a five foot long metal bench and three chairs stored in the path of the four foot sidewalk, blocking the access along the sidewalk to the parking lot. This was verified by the maintenance director at the time of observation. 3.1-19(b)			

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K0046 SS=C	Based on observation and interview, the facility failed to ensure 1 of 1 battery backup lights was tested monthly over the past year, or had annual test to ensure the light would provide lighting during periods of power outages to protect 55 of 55 residents. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents if the generator required repairs during a power outage. Findings include: Based on observation on 04/04/11 at 12:20 p.m. with the maintenance director, the emergency generator transfer switch room had one battery backup light mounted on the wall. Based on an interview with the maintenance director on 04/04/11 at 12:30 p.m., the battery	K0046	No residents were affected by the deficient practice.The battery powered back up light in the emergency generator transfer switch room was tested and found to be working properly. It was tested for 90 minutes.There are no other battery powered back up lighting in facility.The battery powered back up light will be tested weekly and also monthly for 30 seconds and annually for 90 minutes duration by the Maintenance Supervisor.Documentation of testing will be reviewed at the monthly QA meeting for four months.	04/22/2011

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	powered backup light is not tested monthly or tested annually for a ninety minute duration. 3.1-19(b)			

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K0052 SS=F	Based on observation and interview, the facility failed to provide a fire alarm system trouble signal in a location likely to be heard by facility staff in accordance with NFPA 72 the National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors. Findings include: Based on an observation and fire alarm testing with the maintenance director on 04/04/11 at 1:15 p.m., when the automatic dialer component was placed in trouble from phone line failure for twelve minutes, the local trouble signal was initiated at the digital dialer box located in the Service Hall maintenance office, which was not continually occupied. The audible trouble signal alarm could not be heard at the 500/600 Hall nurses' station or at the 200/300 Hall nurses' station and this was verified by the maintenance director at the time of the testing. 3.1-19(b)	K0052	No residents were affected by the deficient practice.Annunciator panel for the automatic dialer will be placed at the 500/600 hall nurses' station.There is only one automatic dialer component in building.The automatic dialer component will be tested weekly x 4 weeks then monthly to by the Maintenance supervisor to assure the audible trouble signal can be heard by staff.Results of testing will be reviewed monthly at QA meeting for four months.	05/02/2011

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K0054 SS=E	Based on observation and interview, the facility failed to ensure 3 of 48 smoke detectors were not located where airflow could prevent the operation of the detector. LSC 9.6.1.3 says the provisions of 9.6 cover the basic functions of a fire alarm system and 9.6.1.4 refers to NFPA 72. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect all residents who use the main dining room in the facility. Findings include: Based on observations on 04/04/11 during a tour of the facility from 11:00 a.m. to 1:30 p.m. with the maintenance director, the Service Hall smoke detector near the maintenance office, the smoke detector in the corridor just outside the main dining room, and the smoke detector in the corridor outside the administrator office were located one foot from return air ducts. This was verified by the	K0054	No residents were affected by the deficient practice. The three smoke detecots identified have been moved so airflow would not prevent the operation of smoke detector. All other smoke detectors were observed in the facility to assure proper location away from airflow.	04/22/2011

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	maintenance director at the time of observations. 3.1-19(b)			

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K0070 SS=E	Based on observation and interview, the facility failed to provide evidence 1 of 1 portable space heating devices in use in the activity room had heating elements which did not exceed 212 degrees F. This deficient practice could affect any residents who use the main dining room, adjacent to the activity room office. Findings include: Based on an interview with the maintenance director on 04/04/11 at 11:10 a.m. at the entrance record review, the facility does not allow portable space heating devices. Based on observation and interview on 04/04/11 at 12:10 p.m., the activity office had a portable space heating device in use and the maintenance director indicated there was no evidence to indicate the heating element does not exceed 212 degrees Farenheit. 3.1-19(b)	K0070	No residents were affected by the deficient practice.The portable space heater in the activity office was removed immediately.The facility was inspected to assure that no other space heating devices were in use in any area.All rooms will be checked weekly for four weeks then monthly by Maintenance supervisor or designee to assure no space heater are in the facility.Audits will be reviewed at monthly QA meeting.	04/22/2011

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K0075 SS=E	Based on observation and interview, the facility failed to ensure soiled linen containers in 1 of 4 corridors did not exceed 32 gallons. This deficient practice could affect any resident using the main dining room, near the exit door in the Service Hall. Findings include: Based on observation on 04/04/11 at 12:05 p.m. with the maintenance director, the Service Hall corridor had two, thirty three gallon soiled linen receptacles stored in the corridor next to the south exit door. The receptacle size was verified on the bottom of each receptacle and this was acknowledged by the maintenance director at the time of observation. 3.1-19(b)	K0075	No residents were affected by the deficient practice.The 33-gallon soiled linen receptacles were immediately removed from the service hall.The 33-gallon soiled linen receptacles were taken out of service. All halls were checked and no other 33-gallon soiled linen receptacles were found.Rounds will be made 5x/wk for four weeks then weekly by housekeeping supervisor or designee to assure no 33-gallon linen receptacles are in halls.Results of rounds will be reviewed at monthly QA meetng for four months.	04/22/2011

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	155267	A. BUILDING 01 B. WING	04/04/2011

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SCOTT VILLA NURSING AND REHABILITATION CENTER	545 W MOONGLO ROAD SCOTTSBURG, IN47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0144 SS=F	Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with a functional alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be	K0144	No residents were affected by the deficient practice.The generator set remote annucnciator panel has been repaired.There are no other generator set remote annunciator panels in facility.The generator is tested weekly and the annuciator panel will be checked when generator is tested weekly to assure proper annunciation.The weekly generator testing will be reviewed monthly at QA meeting for four months.	04/22/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents as well as visitors and staff. Findings include: Based on observation on 04/04/11 at 12:30 p.m. with the maintenance director, a remote alarm annunciator for the generator was provided at the 500/600 Hall nurses' station. The test button on the annunciator panel was depressed and failed to indicate a lighted signal for low oil pressure, low water temperature, low fuel, overcrank, overspeed or emergency power. Based on an interview with the 500/600 Hall charge nurse on 04/04/11 at 12:30 p.m., the emergency power signal did not come on when the generator set was started on 04/04/11 at 12:15 p.m. Based on an interview with the director of maintenance on 04/04/11 at 12:40 p.m., the generator set remote annunciator does not work and is not connected electrically to any emergency generator set component.			

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	3.1-19(b)			

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	155267	A. BUILDING 02 B. WING	04/04/2011

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K0044 SS=E	Based on observation and interview, the facility failed to ensure 1 of 1 fire doors would latch into the door frame. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-.1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires all fire doors to be closed and latched at the time of a fire. This deficient practice affects any resident using the Therapy Hall. Findings include: Based on observation on 04/04/11 at 12:50 p.m. with the maintenance director, the Therapy Hall, which had a thirty six inch wide fire door with a one and one half hour fire resistance rating and separated the existing facility from the Therapy Hall addition, lacked latching hardware. This was verified by the maintenance director at the time of observation. 3.1-19(b)	K0044	No residents were affected by the deficient practice.Latching hardware has been placed on the therapy door that separates the existing facility from the Therapy Hall addition.Maintenance supervisor checked all other doors and latching devices were in place.Doors will be checked weekly for two weeks then monthly by Maintenance supervisor or designee to assure all have latching devices.Audits will be review monthly at QA meeting for four months.	04/22/2011

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K0054 SS=E	Based on observation and interview, the facility failed to ensure 2 of 6 smoke detectors in the therapy addition were not located where airflow could prevent the operation of the detector. LSC 9.6.1.3 says the provisions of 9.6 cover the basic functions of a fire alarm system and 9.6.1.4 refers to NFPA 72. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect all residents who use the therapy room. Findings include: Based on observation on 04/04/11 at 1:30 p.m. with the maintenance director, the two smoke detectors in the center of the therapy room were located one foot from return air ducts. This was verified by the maintenance director at the time of observation. 3.1-19(b)	K0054	No residents were affected by the deficient practice. The three smoke detecots identified have been moved so airflow would not prevent the operation of smoke detector. All other smoke detectors were observed in the facility to assure proper location away from airflow.	04/22/2011